Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a) **Requirements concerning the independent audit of provider agencies**

In accordance with the Maryland Annotated Code Health General Article Title 7 and Code of Maryland Regulations (COMAR) Title 10, Subtitle 22, all DDA licensed providers are required to submit on an annual basis: (1) a cost report documenting the provider's actual expenditures for the fiscal year being reported; and (2) audited financial statements supporting the cost report; (3) a worksheet reconciling the cost report to the financial statement; and (4) a certification by an independent certified public accountant, who is not an employee of the licensed provider or any affiliated organization, that he or she prepared the cost report and financial statement.

(b) and (c) **The State's audit strategies performed by various State agencies**

A. Single State Audit
There is an annual independent audit of Maryland's Medical Assistance Program ("Medicaid") that includes Medicaid's home and community-based waiver programs. The annual audit is conducted by an independent contractor in accordance with Circular A-133. A major focus of this audit is the integrity of providers' claims for payment for services. The contract for this audit is bid out every five years by Maryland's Comptroller's Office.

B. Office of Legislative Audits
The Maryland Office of Legislative Audits conducts independent audits of all State agencies and programs including Medicaid. Medicaid and the Developmental Disabilities Administration are audited on a three-year cycle.

C. Medicaid Management Information System (MMIS)
MMIS is a software database system that Medicaid uses to track all claims for payment for services. Medicaid uses the MMIS to audit claims against edits to prevent payment for claims that exceed established limits, conflict with other services, or represent duplicative services.

D. Developmental Disabilities Administration System Audits
1. The Provider Consumer Information System (PCIS2) is a software database system that DDA uses to track all services provided to participants and providers' resultant claims for payment for those services. The DDA uses PCIS2 to audit claims against authorized services and rates.
2. DDA fiscal staff audits all invoices for non-rate based services and compares them to authorized services as noted in the Service Funding Plan and maintained in PCIS2.

3. The DDA also reviews all MMIS denied claims, conducting trend analysis to determine system issues.
4. All DDA licensed providers are required to attest to the accuracy of all invoices and PCIS2 claims prior to payment.
5. Any suspicion of fraud is referred to the Office of Inspector General (OIG) for investigation.

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Financial Accountability Assurance**
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-assurances:

a Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

a.i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

Performance Measure:	FA - PM1 Number and percent of claims paid in accordance with the approved Waiver. N: Total # of claims paid in accordance with the approved Waiver. D: Total #of claims paid.
Data Source *(Select one) (Several options are listed in the on-line application):* MMIS Reports and PCIS2	
If 'Other' is selected, specify	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	*X 100% Review*
	X Operating Agency	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	*X Quarterly*	☐ *Representative*

				Sample; Confidence Interval =
	☐ Other Specify:	*☐ Annually*		
		☐ Continuously and Ongoing		*☐ Stratified: Describe Group:*
		Other Specify:`		
				☐ Other Specify:

b. Sub-assurance: The State provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measure:	FA PM2 Number and percent of provider payment rates that are consistent with rate methodology approved in the approved Waiver application. N: # of provider rates paid consistent with approved methodology in paid claims. D: # of claims reviewed for provider rates.
Data Source *(Select one) (Several options are listed in the on-line application):*MMIS Reports, PCIS**2**	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	X Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*X Quarterly*	*☐ Representative Sample; Confidence Interval =*
	√ Other Specify: Utilization Review Contractor	*☐ Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			Other Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.*

If the DDA identifies any systemic problems, then the DDA reports these problems to Medicaid for correction. Any incorrectly paid claims would be adjusted accordingly.

The DDA reviews MMIS and PCIS2 paid claims reports on a monthly basis to determine if any claims were paid with an incorrect procedure code. Those incorrectly paid claims would count as non-compliant. Medicaid will research MMIS for system issues to identify causes for failures with the MMIS coding.

In addition, the DDA reviews MMIS and PCIS2 reports on a monthly basis to verify that the established reimbursement rate is paid for each rate-based claim. Rate limits for rate-based services are programmed in MMIS, so claims processed with rates higher than the established rates in MMIS would be denied. If the MMIS system pays above the established rate for the year, then there would be a system problem and the paid claims would be considered non-compliant. Medicaid will research MMIS for system issues to identify causes for failures with the MMIS coding.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
	☐ **State Medicaid Agency**	☐ **Weekly**
	√ **Operating Agency**	☐ **Monthly**
	☐ **Sub-State Entity**	☐ **Quarterly**
	☐ **Other** Specify:	√ **Annually**
		☐ **Continuously and Ongoing**
		☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

✓	**No**
	Yes

APPENDIX I-2: Rates, Billing and Claims

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The program includes rate-based services and non-rate based services.

Non-Rate-Based Services

The following services are deemed non-rate based services: Assistive Technology Services, Environmental Modifications, Individual & Family Goods and Services, Vehicle Modifications, Family Caregiver Training & Empowerment Services, Respite Care Services, Support Broker Services, Transportation, and Participant Education, Training & Advocacy Supports.

Payment for non-rate-based services are based on the specific needs of the individual and the piece of equipment, type of modifications, workshops, classes, or service design and delivery method as documented in the PCP. The applicable service definition set forth in Appendix C provides any additional requirements for payment of these non-rate based services.

Rate Based Services

The following services are deemed rate-based services: Behavioral Support Services, Day Habilitation Services, Community Development Services, Employment Discovery & Customization, Environmental Assessment, Medical Day Care, Personal Supports, Supported Employment, Transitional Employment Services, and Family & Peer Mentoring. Family and Peer Mentoring services are a new service that was based on a review of states providing similar services.

Personal Supports, Day Habilitation Services, Community Development Services, Employment Discovery & Customization, Supported Employment, and Transitional Employment Services include regional rates that are outlined in the DDA's regulations and based on the State's Community Pathways waiver. On a yearly basis, rates are evaluated for a Cost of Living Adjustment (COLA) by the Maryland Department of Budget and Management. The COLA is approved by Maryland's General Assembly.

Environmental Assessment and Medical Day Care rates are based on similar Medicaid programs.

Transitional Employment Services rates are based on the rate for Supported Employment.

Rate Study

In accordance with State law (Chapter 648 of the Acts of 2014), the DDA procured a contractor to conduct an independent and cost-driven rate setting study and obtain input from stakeholders, including individuals receiving services and providers. The contractor will be conducting public listening sessions in the Fall of 2017 based on their findings. Any changes to current service rate covered under this program will be updated with a waiver amendment.

In accordance with the findings and recommendations of the rate-setting study, the DDA will

continue to review and amend as necessary the Community Supports waiver service rates based on the rate setting methodology for comparable services and based on actual cost.

Development of Rates for New Services

The following are new services being offered by the DDA under this waiver for which historic rate data does not exist: Family Caregiver Training and Empowerment Services; Family and Peer Mentoring Supports; and Participant Education, Training and Advocacy Supports. For new services, DDA has collected data costs of similar services provided through agencies in Maryland and surrounding states. The rates for these new services are based on similar services in Arizona's Raising Special Kids program and applying Maryland cost values to derive the rates. The Maryland cost values were provided by Johnston, Villegas-Grubbs and Associates, LLC, the rate setting vendor.

Promulgation of New Rates and Adjustments in Rates

Rates for rate-based services, except for Behavioral Support Services, Environmental Assessments, and Medical Day Care, are set forth in DDA's regulations. Rates are available on the DDA website and rate changes are made through the regulatory process which includes publication in the Maryland Register. New services rates and any rate changes are published in the Maryland Register and include a 30-day public comment period as required by law. The last amendment to the rates occurred on or about July 1, 2017. The DDA's rates vary slightly based on the federally recognized wage enhancement areas. Wage enhancement areas result in slightly higher service rates for Washington DC Metro and Wilmington Metro.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

The flow of billings for waiver services based on which service delivery model the participant is enrolled in: Traditional Services Model or Self-Directed Services Model.

Billings under the Traditional Services Delivery Model

Personal Supports, Day Habilitation Services, Community Development Services, Employment Discovery & Customization, and Supported Employment claims are submitted electronically through the DDA's electronic data system called PCIS2 which interfaces with the MMIS system to generate federal claims. PCIS2 data collects information on: (1) the services included in the participant's Person-Centered Plan (PCP) that can be billed; (2) the approved services and individualized budget set forth in the Service Funding Plan (SFP); and (3) the services actually rendered by the provider. PCIS2 checks the PCP and SFP against the services actually rendered to ensure that overbilling or billing for services not in the PCP or SFP does not occur.

In addition, MMIS has in place a series of coding system "edits" that prevent billing for two or more services that cannot occur at the same time. Claims that are rejected by MMIS due to system edits are reviewed by the DDA federal billing unit. Based on this review, if the services were actually rendered in accordance with the PCP and SFP, the claim will be paid either with State funds only (if not a waiver-covered service), or, the claim is corrected and resubmitted (if a waiver-covered service). If the services were not actually rendered, then the claim is denied.

Behavioral Support Services, Environmental Assessments, Medical Day Care, Family Caregiver

Training and Empowerment Services, Family and Peer Mentoring Supports, Participant Education, Training and Advocacy Supports and Transitional Employment Services and non-rate-based services are claimed via either a paper billing process using the CMS 1500 Form or direct submission by the provider into MMIS. The CMS 1500 is completed by the provider of services and submitted to DDA for review. If the CMS 1500 is consistent with the participant's SFP based on his or her PCP, then the DDA submits the claim to Medicaid to be entered into the MMIS system. Providers may also directly submit these service claims electronically to MMIS. Claims that are rejected by MMIS are reviewed by the DDA federal billing unit. Based on this review, if the services were actually rendered in accordance with the PCP and SFP, the claim will be paid either with State funds only (if not a waiver-covered service), or, the claim is corrected and resubmitted (if a waiver-covered service). If the services were not actually rendered, then the claim is denied.

Billings under the Self-Directed Services Delivery Model

For participants enrolled in the Self-Directed Services Model (as described in Appendix E), the Fiscal Management Service (FMS) compares employee timesheets or invoices against the DDA-approved plan and annual budget for processing. For claims that match, the FMS then submits them to MMIS. Claims that are rejected by MMIS are reviewed by the DDA federal billing unit. Based on this review, if the services were actually rendered in accordance with the PCP and SFP, the claim will be paid either with State funds only (if not a waiver-covered service), or, the claim is corrected and resubmitted (if a waiver-covered service). If the services were not actually rendered, then the claim is denied.

c. Certifying Public Expenditures *(select one)*:

√	**No**. **State or local government agencies do not certify expenditures for waiver services.**
○	**Yes**. **State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.** *Select at least one:*
☐	**Certified Public Expenditures (CPE) of State Public Agencies**. Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)
☐	**Certified Public Expenditures (CPE) of Local Government Agencies**. Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Payments for all waiver services are made through the approved Medicaid Management Information System (MMIS). The claim for Federal Financial Participation (FFP) is based on the initial processing and review of the provider claim by the DDA or its agent and the subsequent review of the provider claim by the OHS through MMIS.

a) **Verification of Eligibility for a Medicaid Payment on the Date of Service**

MMIS edits are in place to validate the participant's waiver enrollment on the date of service and established service limitations. Requests are made for FFP based on claims processed through the MMIS. The FFP claim is based on the review of the paid provider claim by Medicaid while consumer eligibility information is ultimately maintained by Medicaid, eligibility information within the DDA claims processing information is updated on a regular basis. The information includes both the service plan and the effective dates of coverage. The claims are subject to the full edits of the DDA and Medicaid systems. Claims eligible for FFP are submitted to the Medicaid system for additional review and for the collection of FFP.

b) **Verification that the service was included in the participant's approved service plan**

As specified in further detail in Appendix I-2, subsection b. above, the DDA generally verifies the claim against the PCP and SFP (under the Traditional Services delivery model) and the DDA-approved annual budget (under the Self-Directed Services delivery model). Please refer to Appendix I-2, subsection b. above for further details about these processes.

c) **Verification of Service Provision**

The participant's Coordinator of Community Service (CCS) perform quarterly monitoring, which includes inquiring whether the participants are receiving the services indicated in the PCP and the SFP for participants enrolled in Traditional Services or the DDA-approved annual budget for participants enrolled in Self-Directed Services Model. They complete this task by interviewing the participant, family members, and staff. Audits of service provision are also conducted by DDA (see Appendix I-1). DDA also requires that each licensed provider be audited by an independent auditor consistent with Circular A-133, as further specified in Appendix I-1.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.

APPENDIX I-3: Payment

a. Method of payments — MMIS *(select one)*:

√	**Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
○	**Payments for some, but not all, waiver services are made through an approved MMIS.** Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
○	**Payments for waiver services are not made through an approved MMIS.** Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
○	**Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.** Describe how payments are made to the managed care entity or entities:

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

√	**The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
☐	**The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
√	**The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.** Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:
	For participants enrolled in the Self-Directed Services Delivery Model (as described in Appendix E), waiver services are paid by the FMS and then the FMS submits the claim through MMIS. DDA provides oversight of the FMS providers by conducting an annual audit. The audit monitors and assesses the performance of the provider including ensuring the integrity of the financial transactions that they perform.

☐	**Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.** Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

√	**No**. **The State does not make supplemental or enhanced payments for waiver services.**
○	**Yes**. **The State makes supplemental or enhanced payments for waiver services.** Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

○	**No**. **State or local government providers do not receive payment for waiver services.** *Do not complete Item I-3-e.*
√	**Yes**. **State or local government providers receive payment for waiver services.** *Complete item I-3-e.* Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish. *Complete item I-3-e.*
	Some local governments provide Respite services.

e. **Amount of Payment to State or Local Government Providers**.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one*:

√	**The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
○	**The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**

○	**The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.** Describe the recoupment process:

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

√	**Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
○	**Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.** Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

○	**No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
√	**Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).** Specify the governmental agency (or agencies) to which reassignment may be made.
	Under the current payment methodology, reassignment may be made to the Developmental Disabilities Administration (DDA).

ii. Organized Health Care Delivery System. *Select one:*

○	**No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
√	**Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.** Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured

	when an OHCDS arrangement is used:
	a) A potential provider interested in becoming an OHCDS may apply to do so as part of initial licensure or by amending their current license and must meet all regulatory requirements outlined in Code of Maryland Regulations (COMAR) Title 10, subtitle 22. b) Other DDA licensed providers may provide services directly and are not required to contract with an OHCDS. To become a licensed or approved provider, the entity can contact the DDA for an application or find the application on the DDA's website. c) The Coordinator of Community Services (CCS) supports participants and their legal representatives and families by sharing information about the various services, providers, and service delivery models available. Participants may choose a DDA licensed or approved provider, an OHCDS, or other providers, such as FMS or direct care staff, under the Self-Directed Services Model. Maryland regulations prohibit providers from infringing on an individual's right to choose freely among qualified providers at any time d) An OHCDS must attest that all provider qualifications are met as set forth in regulations and provide supporting documentation upon request. e) As part of the DDA's quality assurance procedures, the DDA surveys OHCDS providers for their compliance with regulatory requirements, including those requirements governing contracts with qualified providers. f) Billing for OHCDS contract services are completed using the CMS 1500 Form or by direct provider electronic submission in the MMIS system. The DDA and Medicaid review all claims submitted. Accountability efforts also include Single State and Independent audits as further detailed in this Appendix I.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

√	**The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
○	**The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.** Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and (d) how payments are made to the health plans.
○	**This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid**

	inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
○	**This waiver is a part of a concurrent §1115/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1115f waiver specifies the types of health plans that are used and how payments to these plans are made.**

APPENDIX I-4: Non-Federal Matching Funds

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

√	**Appropriation of State Tax Revenues to the State Medicaid agency**
☐	**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.** If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:
☐	**Other State Level Source(s) of Funds.** Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select one:*

○	**Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
√	**Applicable** *Check each that applies:*
√	**Appropriation of Local Government Revenues.** Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

		Intergovernmental Transfer nominal amount that has not changed since 1986.
	☐	**Other Local Government Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds . *Select one:*

√	**None of the specified sources of funds contribute to the non-federal share of computable waiver costs.**	
○	**The following source(s) are used.** *Check each that applies.*	
	☐	**Health care-related taxes or fees**
	☐	**Provider-related donations**
	☐	**Federal funds**
	For each source of funds indicated above, describe the source of the funds in detail:	

APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

√	**No services under this waiver are furnished in residential settings other than the private residence of the individual.**
	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

√	**No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
○	**Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

√	**No. The State does not impose a co-payment or similar charge upon participants for waiver services.** (*Do not complete the remaining items; proceed to Item I-7-b*).
○	**Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.** (*Complete the remaining items*)

i. Co-Pay Arrangement

Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies)*:

	Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*
☐	**Nominal deductible**
☐	**Coinsurance**
☐	**Co-Payment**
☐	**Other charge** *Specify*:

ii Participants Subject to Co-pay Charges for Waiver Services.

Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded

iii. Amount of Co-Pay Charges for Waiver Services. The following table lists the waiver services defined in C-1/C-3 for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Charge	
	Amount	Basis

iv. Cumulative Maximum Charges.

Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

○	**There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.**
○	**There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.** Specify the cumulative maximum and the time period to which the maximum applies:

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

√	**No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
○	**Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.** Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income (c) the groups of participants subject to cost-sharing and the groups who are excluded; and (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64: